NationalJournalMember

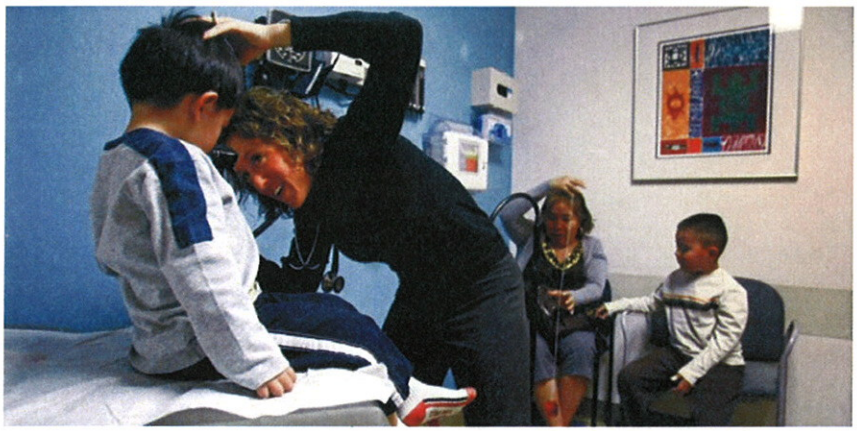
HEALTH

Adapt or Else

Whether it wants to or not, the health care system is being forced to reinvent itself.

by **Matthew DoBias**

Thursday, March 10, 2011 | 4:00 p.m.



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Say aaaah: The health care law makes primary-care physicians the fulcrum of a new delivery system.

In April 2010, one month after President Obama signed the law overhauling nearly every aspect of the U.S. health care system, physicians at Summit Medical Group in Knoxville, Tenn., spent the day plotting a reform course of their own.

Summit's chief executive, Tim Young, and the board members who govern the medical group had tracked the law's legislative twists and turns from the start. They understood the contours of the package even when political jockeying in Washington clouded the eventual outcome. As best they could, they focused on the policy, not the politics.

What Young and the 200-plus doctors at Summit came to realize was that the law's key goals hewed closely to their own. The dozens of provisions geared toward improving and streamlining patient care were similar to many of the initiatives the medical group either had in place or planned to implement.

In fact, nearly a year earlier, Summit's physicians had begun discussing how best to integrate care—not only in their own practices but also in the Knoxville medical community as a whole. They decided to take the unusual step of forging alliances with two competing hospitals to form what is somewhat nebulously described as an accountable care organization.

"It wasn't the first time [our doctors had] heard about an integration strategy," Young said of health care reform. "It wasn't news to them." In a vote last November, 90 percent of Summit's

practicing physicians backed the ACO option, a stunningly high number when you consider the fierce independent streak common among physicians. Last week, Summit received letters of agreement with the hospitals to form one of the largest accountable care organizations in Tennessee.

At more than 2,700 pages, the health reform law may be dense, abstruse, and complex, but it's not necessarily new. Holding the promise of reshaping the country's entire health care system, the act is a clearinghouse, of sorts, for policies that have circulated among health care analysts for years but struggled to gain traction.

The law has changed that dynamic and, with it, the tone and tenor of the way health care providers communicate with each other and their patients. Just a year in, it has reshaped the conversation in fundamental ways. In the past, quality-improvement and patient-safety initiatives either took root or they didn't. Now, facing an explicit directive, providers know they must improve care—or else. For members of the medical community, there's no going back.

And even if they could go back, why would they? That way lies a jumbled mess of paperwork, repeated and misused tests, and sometimes-misguided care. You only have to experience it as a patient once to fully understand the shortcomings of the system that has no clear lines of communication among patients, physicians, and other caregivers.

The good news is that peppered throughout the reform package are measures aimed at changing the system in tangible ways. Taken as a whole, these provisions are designed to break old habits, not just among providers but also throughout a society that has become increasingly sedentary and bloated. In many respects, that's a fairly accurate description of the American population—and of its health care system, too.

The law hoists change upon an industry that has been reluctant at best, fiercely opposed at worst, to try new things. It reshuffles hospital payments and puts a premium on the quality, rather than the amount, of care delivered. It punishes providers for lax patient care and rewards those that boost quality. It redefines primary-care physicians as the fulcrum of a new, improved delivery system.

To be sure, you'd be hard-pressed to find anyone who doesn't think the system is in need of a shake-up. The medical industry developed in silo-like fragments, each of which set up its own payment and reimbursement practices. As a result, federal and private insurers' reimbursement patterns have grown increasingly out of whack, rewarding volume and, in some instances, mistakes.

The system's breaking point has occurred at a time when care has become more complex. Physicians are ill-advised to try to go it alone these days. Instead, the law demands that someone should be coordinating care across many specialties and levels. It's not enough for a physician to simply treat a patient in the examining room. Now, he or she must also treat patients in the bedroom, in the kitchen, in the hospital, and at all points in between.

"TECTONIC SHIFTS"

Long before he took the reins at the Centers for Medicare and Medicaid Services, Donald Berwick, a pediatrician by training, preached the gospel of improved patient care. For many patients, the health care experience had become frustrating and cumbersome. The actual care itself was only middling. Berwick winced at the volume of medical errors that made headlines and cringed because he knew that many more went unnoticed.

In a speech last week to the Federation of American Hospitals, Berwick described what he calls "tectonic shifts" in health care brought on by the globalization of medicine. "Health care is nothing like it used to be," he said. "It brings entirely new challenges to us."

Predictably, these changes cause anxiety within the medical community. Yet Berwick is adamant that reform is the only option. Ever the optimist, he told the crowd of hospital executives to "notice the opportunities."

"All of us wonder about the future," he acknowledged. "It can make us nostalgic for a remembered past that seemed simpler, perhaps."

This is the context for the health care reform. The law is as much a toolbox as it is a compass. If providers follow its compass and use its tools creatively, Berwick said, the nation's health care system will emerge stronger, better, leaner. "Your old business plans are not going to work anymore," he warned. "Change is possible as never before. [Providers] will begin by accepting the realities and then, I hope, by diving in to the challenges to achieve the successes we want."

"Hospitals are racing to re-create themselves." —John Chessare, president, Greater Baltimore Medical Center

Berwick should be heartened to know that the future has indeed begun. Like no time before, physicians, hospitals, and insurers are immersed in a dialog about how to improve care and make payment sustainable. The discussion is difficult. It involves a subtle shift in power, away from costly hospitals toward primary care, where patients encounter more comprehensive treatment. One testimonial to just how dysfunctional the old system has become is that so many providers have championed this vision of reform, even if it comes at a cost.

John Chessare, president and chief executive officer of the Greater Baltimore Medical Center, says he witnessed an "aha" moment when he met with his hospital's board in October to discuss some of the changes he saw coming. Before the meeting, he asked each member to read Atul Gawande's June 2009 *New Yorker* article, "The Cost Conundrum," detailing the misaligned incentives in today's health care system.

"We were trying to educate the board on the need for reform," Chessare said.

He describes a moment when several of the primary-care physicians at the meeting described gaps in the continuum of care "and how it was so hard to actually get the kind of care for an individual [that] you would want for your own loved one." The doctors ticked off a list of problems: scarce services, inaccessible providers, not enough money flowing to primary care.

"It was at that point the board really started to get it," Chessare said. A blueprint emerged. With the board's approval, the medical center would work to achieve what CMS's Berwick coined as the "triple aim" of reform: better care, better health, and lower costs.

What came next was a series of strategies emblematic of what other health care systems have done in the year since the reform law took hold. The medical center organized its phalanx of primary -care physicians, forming the Greater Baltimore Health Alliance, which functions as a de facto ACO. Providers' ticket for entry, Chessare said, is dedication to improving care through quality measurement and reporting. Physicians must adhere to Berwick's triple aim, no matter how humbling
the results.

A FOCUS ON PATIENTS

The health reform law does more than just nudge executives to improve clinical outcomes and control costs. It gives them the framework to create an accountable care organization under the Medicare payment structure. To streamline and deliver high-value care, the federal government wants health care organizations to be anchored by hospitals, physicians, nurses, and other key providers. If coordinating care saves money, ACO members all get a share.

The program's roots are embedded in Medicare's five-year Physician Group Practice Demonstration, which created financial incentives for doctors to more closely follow the care their Medicare patients were receiving. Ten physician groups participated in the project, and although not all of them earned the potential bonus payment, each improved the quality of patient care.

Outside of Medicare, private insurers pioneered versions of ACOs, often contracting directly with hospitals or physician groups. Beginning in the 1980s and '90s, physicians formed partnerships with each other and
with private insurers to form health maintenance organizations to provide total care to participants. Often, the care was reimbursed at a flat rate.

As a result of the coordination, the physician groups effectively began to make decisions more typical of insurers. They decided what services were covered and who would deliver them. The idea was to deliver patient care on a budget. It worked to an extent. Costs grew at a much slower clip, although criticism grew that physicians were holding back care to keep costs down.

Physicians want accountable care organizations to mirror the good parts of the HMO experience and mitigate the rest. The law